



PANDEMIC INFLUENZA U • P • D • A • T • E



Public Health Prepares

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Fast Facts

Imported pet birds and poultry from countries affected by avian influenza (H5N1) pose some public health risk

- The U.S. Department of Agriculture (USDA) maintains trade restrictions and regulations on the importation of poultry and poultry products from H5N1-affected countries.
- Importation of live poultry, commercial birds, pet birds, and/or “hatching eggs” from H5N1-affected countries into the United States is not allowed.
- All pet birds and live poultry from countries that are allowed to export them into the United States (except Canada) must be quarantined for at least 30 days at a USDA animal import center and tested for the avian influenza virus.

For a complete list of countries affected with H5N1, go to the USDA website:

<http://www.aphis.usda.gov/>

If You are Asked . . .

“So, what is the difference between low pathogenic avian (LPAI) influenza and high pathogenic avian influenza (HPAI) in birds?”

Avian influenza viruses are classified as LPAI and HPAI based upon the severity of the illness for birds.

LPAI: Most avian flu strains are classified as LPAI and typically cause little or no clinical signs of illness in infected birds; these viruses pose little risk to humans.

According to USDA Secretary, Mike Johanns, LPAI has been in the United States for more than 100 years. One way to describe LPAI is that birds have a flu season much like humans. The low-path variety of avian influenza may go undetected and usually causes mild symptoms such as ruffled feathers and a drop in egg production.

HPAI: HPAI causes severe illness and death in poultry. Certain HPAI viruses, particularly the H5N1 viruses, have also caused severe disease and deaths in humans. Thus, the rapid spread of H5N1 HPAI is of growing concern for human health as well as for animal health.

Secretary Johanns states that the USDA has dealt with high-path avian influenza before in the United States. In 2004, there was an outbreak of high-path H5N2, avian influenza among poultry in Texas. And before that, in the 1980s, there was high-path H5N2 avian influenza among poultry in Virginia and Pennsylvania.

To read more of Secretary Johanns' remarks and a glossary of terms, go to <http://www.pandemicflu.gov/>.

(To date there are no reported cases of H5N1 avian influenza in the United States)

PANDEMIC INFLUENZA UPDATE

Public Health Prepares . . .

The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) were charged by Congress in 1999

to establish the National Pharmaceutical Stockpile (NPS). The mission was to provide a re-supply of large quantities of essential medical material to states and communities during an emergency in the United States or its territories within 12 hours of the federal decision to deploy. The Strategic National Stockpile (SNS) Program is part of a nationwide preparedness training and education program for state and local health care providers, first responders, and governments. This training not only explains the SNS Program's mission and operations, it also alerts state and local emergency response officials to the important issues they must plan for in order to receive, secure, and distribute SNS assets to states.

As there is no current Food and Drug Administration (FDA) approved vaccine for the H5N1 virus, HHS is in the process of procuring "pre-pandemic vaccine," which is vaccine developed and based on current strains of H5N1 (prior to a pandemic).

States are prepared to receive SNS medicine and medical supplies for distribution as needed, depending on the event.

During a public health emergency, you would find out about how to get medicine to protect you and your family by watching TV, listening to the radio, reading the newspaper, checking the community Web site on the Internet or learning from trusted community leaders. For more information on the Strategic National Stockpile go to <http://www.bt.cdc.gov/stockpile/>.

Update on H5N1: Global Activity Humans and Birds

Humans: During outbreaks since 2004, there have been **228** confirmed cases in humans and **130** deaths as of June 20, 2006. They occurred in the following nations: Vietnam 93 cases and 42 deaths; Thailand 22 cases and 14 deaths; **Indonesia** 51 cases and 39

deaths; **China** 19 cases and 12 deaths; Turkey 12 cases and 4 deaths; Iraq 2 cases and 2 deaths; Azerbaijan 8 cases and 5 deaths; **Egypt** 14 cases and 6 deaths; **Djibouti** 1 case and 0 deaths.

Birds: Since December 2003, avian influenza A (H5N1) infections in poultry or wild birds have been reported in the following regions/countries as of June 20, 2006: ASIA (Cambodia, China, Hong Kong, India, Indonesia, Laos, Malaysia, Myanmar, Pakistan, Thailand, and Vietnam); CENTRAL ASIA and the MIDDLE EAST (Afghanistan, Azerbaijan, Georgia, Iraq, Iran, Israel, Jordan, Kazakhstan, Palestine Autonomous Territories, and Turkey); AFRICA (Egypt, Burkina Faso, Cameroon, Cote D'Ivoire, Niger, Nigeria, Djibouti, and Sudan); EUROPE (Albania, Austria, Bosnia/Herzegovina, Bulgaria, Croatia, Czech Republic, France, Denmark, Germany, Greece, Hungary, Italy, Poland, Romania, Russia, Siberia and Montenegro, Slovakia, Slovenia, Sweden, Switzerland, Ukraine, and United Kingdom).

CDC Recommends . . .

Updated Interim Guidance for Laboratory Testing of Persons with Suspected Infection with Avian Influenza A (H5N1) Virus in the United States

CDC Health Update

This update provides revised interim guidance for testing of suspected human cases of avian influenza A (H5N1) in the United States and is based on the current state of knowledge regarding human infection with H5N1 viruses. The epidemiology of H5N1 human infections has not changed significantly since February 2004. Therefore, CDC recommends that H5N1 surveillance in the United States remain at the enhanced level first established at that time. However, this revised interim guidance provides an updated case definition of a suspected H5N1 human case for the purpose of determining when testing should be undertaken and also

PANDEMIC INFLUENZA UPDATE

provides more detailed information on laboratory testing. Effective surveillance will continue to rely on health care providers obtaining information regarding international travel and other exposure risks from persons with specified respiratory symptoms as detailed in the recommendations below. This guidance will be updated as the epidemiology of H5N1 changes. Note: CDC is revising its interim guidance for infection control

precautions for avian influenza A (H5N1). These will be issued as soon as they are available.

Current Situation

The avian influenza A (H5N1) epizootic (animal outbreak) in Asia has expanded to wild birds and/or poultry in parts of Europe, the Near East and Africa. Sporadic human infections with H5N1 continue to be reported and have most recently occurred in China, Egypt, Indonesia, Azerbaijan, Cambodia, and Djibouti. In addition, rare instances of probable human-to-human transmission associated with H5N1 viruses have occurred, most recently in a family cluster in Indonesia. So far, however, the spread of H5N1 virus from person to person has been rare, inefficient, and unsustainable. The total number of confirmed human cases of H5N1 reported as of June 7, 2006 has reached 228. The case fatality rate for these reported cases continues to be approximately 50 percent. As of this date, H5N1 has not been identified among animals or humans in the United States.

The epizootic in Asia and parts of Europe, the Near East and Africa is not expected to diminish significantly in the short term and it is likely that H5N1 infection among birds has become enzootic in certain areas. It is expected that human infections resulting from direct contact with infected poultry will continue to occur in affected countries. Since no sustained human-to-human transmission of influenza H5N1 has been documented anywhere in the world, the current phase of alert, based on the World Health Organization (WHO) global influenza preparedness plan, remains at Phase 3 (Pandemic Alert). In addition, no evidence for genetic reassortment between human and avian influenza A virus genes has been found. Nevertheless, this

expanding epizootic continues to pose an important and growing public health threat. CDC is in communication with WHO and other national and international agencies and continues to monitor the situation closely.

Reporting and Testing Guidelines

CDC recommends maintaining the enhanced surveillance efforts practiced currently by state and local health departments, hospitals, and clinicians to identify patients at increased risk for avian influenza A (H5N1). Guidance for enhanced surveillance was first described in a HAN update issued on February 3, 2004 and most recently updated on February 4, 2005.

Testing for avian influenza A (H5N1) virus infection is recommended for:

A patient who has an illness that:

- requires hospitalization or is fatal; AND
- has or had a documented temperature of $\geq 38^{\circ}\text{C}$ ($\geq 100.4^{\circ}\text{F}$); AND
- has radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established; AND
- has at least one of the following potential exposures within 10 days of symptom onset:
 - A) History of travel to a country with influenza H5N1 documented in poultry, wild birds, and/or humans AND had at least one of the following potential exposures during travel:
 - direct contact with (e.g., touching) sick or dead domestic poultry;
 - direct contact with surfaces contaminated with poultry feces;
 - consumption of raw or incompletely cooked poultry or poultry products;
 - direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1; OR
 - close contact (approach within 1 meter [approx. 3 feet]) of a person who was hospitalized or died due to a severe unexplained respiratory illness.
 - B) Close contact (approach within 1 meter [approx. 3 feet]) of an ill patient who was confirmed or suspected to have H5N1; OR

PANDEMIC INFLUENZA UPDATE

C) Worked with live influenza H5N1 virus in a laboratory.

Testing for avian influenza A (H5N1) virus infection can be considered on a case-by-case basis, in consultation with local and state health departments, for:

- A patient with mild or atypical disease‡ (hospitalized or ambulatory) who has exposures listed above (criteria A, B, or C); OR
- A patient with severe or fatal respiratory disease whose epidemiological information is uncertain, unavailable, or otherwise suspicious but does not meet the criteria above (examples include: a returned traveler from an influenza H5N1-affected country whose exposures are unclear or suspicious, a person who had contact with sick or well-appearing poultry, etc).

Clinicians should contact their local or state health department as soon as possible to report any suspected human case of influenza H5N1 in the United States.

Where to Find Out More . . .

WASHINGTON, DC - The U.S. Agency for International Development (USAID) announced a \$5 million award to support the development of a global network to track avian influenza, with the aim of monitoring the role of migratory birds. The Global Avian Influenza Network for Surveillance, or GAINS, will enhance international efforts to collect and analyze laboratory samples from wild birds and identify genetic changes in the virus. The entire award package totals \$6 million, including a \$1 million contribution from the Centers for Disease Control and Prevention.

Read the entire article at www.usaid.gov.

Pandemic Influenza Update: Reader's Feedback

NOTE: The Pandemic Influenza Update will be published once a month beginning March, 2006. It is prepared by CDC's Office of Enterprise Communication. Information in this newsletter is time sensitive and evolving. Readers are welcome to comment by email to PANUPDATE@CDC.GOV

